80-3 OFFICIAL

TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State of Colorado

Attachment 4.19-B
Page 2 A

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

4. Transportation - Reimbursement shall be made according to the following:

A. Land and air ambulance - Reimbursement shall be made for submitted charges or maximum charges as determined by the Department of Social Services, whichever is less. Maximum charges will be set by the State utilizing Medicare charges and submitted charges and will be reviewed periodically.

B. Wheel chair car - Reimbursement shall be made for submitted charges or maximum charges as determined by the Department of Social Services, whichever is less. Maximum charges will be set by the State utilizing submitted charges and will be reviewed periodically.

C. Other - Reimbursement for transportation provided through the counties will be made at reasonable charges for the least expensive transportation which fits the patient's needs and which will not exceed maximum amounts established by the State for certain modes of transportation.

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TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State of Colorado

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-OTHER TYPES OF CARE

Family Planning

A. Payment for family planning services to physicians, hospitals, pharmacies, etc., will be made according to reimbursement methods described for each provider group.

B. Payment for family planning services through an agency contracting with the Department of Social Services will be a rate negotiated yearly to cover an agreed set of services for all Medicaid recipients seeking services through the agency. The rate may not exceed the sum of the reimbursements if the services were performed separately by various providers in Part A above. Services which are not generally used by all clients will be paid at a negotiated rate which may not exceed the rate paid to a provider in Part A above. Payment levels for each service will be reviewed each year during negotiations.

ST. Colorado SA Approved 1/12/81
HO Approved 10/6/81 Effective 1/1/81

State of Colorado

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Pharmaceutical Services

Reimbursement shall be based upon the lower of usual and customary charges to the public or cost of the drug plus a designated professional fee.

A. Ingredient cost shall be defined as the lowest of the following:

1. Estimated Acquisition Cost (EAC) is the lower of the modified Average Wholesale Price or the modified direct cost to the wholesaler or pharmacy. The modified Average Wholesale Price is Average Wholesale Price (as determined from the First Data Bank automated price updating service) less 10.00%, except for certain high volume single source drugs or multi-source drugs with bioequivalence problems. The pricing for these high volume EAC drugs shall be lower than Average Wholesale Price less 10.00%, based on a state-wide survey and recommendations of the Colorado Drug Formulary Advisory Committee and will be based upon package sizes greater than 100 or pints. The modified direct cost is the direct cost plus a handling fee. EAC for medical institutions, clinic pharmacies and government owned or operated pharmacies shall be the actual cost of the ingredient, if less than the Average Wholesale Price less 10.00% or direct cost plus a handling fee. The source of pricing shall be obtained from a national automated price-updating services, local wholesalers, manufacturers, or publications, whichever the state determines is appropriate for the area.

2. Maximum Allowable Cost (MAC) for certain designated high usage multi-source drugs. State MAC's are determined based upon recommendations of the Colorado Drug Formulary Advisory Committee. Federal MAC's shall be adopted if the state MAC is higher or non-existent. MAC exceptions must be prior authorized.

B. Designated professional fees shall be established at reasonable levels by basing these fees upon a periodic cost survey conducted to determine the cost of filling a prescription, and by comparisons with fee standards in surrounding state Medicaid and third party programs. These determinations will apply as follows:

Dispensing fees shall be based upon cost survey information, and area prevailing fee's in other third party and state Medicaid programs. The State will conduct a biannual cost survey in association with the University of Colorado School of Pharmacy. Under no conditions shall the level of payment exceed the amount identified in this survey. The most recent survey indicates the cost of dispensing to be $4.58 for pharmacies and $2.29 for institutions.

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TN No. 90-03

Supersedes
TN No. 88-10

State of Colorado

METHODS AND STANDARD FOR ESTABLISHING PAYMENT RATES - NURSING HOME CARE

5. Reimbursement for Prostheses

Prostheses are reimbursed the lower of charges or maximum reasonable cost. Reasonable cost is defined as the maximum allowable amount established by the Department or, when a maximum allowable amount has not been established for an item, provider's invoice cost plus 20% plus freight.

6. Billing and payment of oxygen supplies and services for nursing facility Medicaid residents.

A. Effective with the service month of March 1, 1991, all oxygen supplies except oxygen provided by oxygen concentrators (when owned by nursing facilities) shall no longer be reimbursed by the Medicaid program on the nursing home claim form. Oxygen concentrator expenses (when owned by the nursing facility), shall continue to be reimbursed on the nursing home claim as specified in Section X.1.B. below.

1. Liquid, piped in and gaseous oxygen, as well as equipment and supplies provided by the medical equipment supplier for administration in a nursing facility, shall be billed directly to the Department's Fiscal Agent by the medical supply provider.

2. The Medicaid supplier shall bill the Medicaid program based upon information provided by the nursing home,using the appropriate HCPCS codes relating to liquid/gaseous oxygen or the equipment/supplies necessary for its administration. Reimbursement shall be made in accordance with the Department's fee schedule or the provider's usual and customary charges, whichever is lower.

B. Oxygen concentrators purchased by nursing facilities.

1. Oxygen concentrators purchased by nursing home providers on or after March 1, 1991 shall be billed on the nursing home claim form at a fee of $175.00 per month of service. All supplies, equipment and service costs associated with the concentrators (purchased after March 1, 1991) are to be covered by the $175.00 per month fee.

2. Payment of the $175.00 per month fee shall only continue through service date February 28, 1992. After this date payment through the nursing home claim form shall no longer be made.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State of Colorado

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

6. Private Duty Nursing – Private Duty Nursing services provided to eligible clients by Medicaid certified home health agencies shall be reimbursed in units of one hour.

The unit rate is the lower of billed charges or the maximum rate established by the State Medicaid agency.

Unit rates were originally based on prevailing rates for private duty care in Colorado, adjusted to the client's acuity level. The acuity level for each client's care was calculated by the State Medicaid agency and a corresponding rate was applied. Over time, the acuity levels were adjusted to account for the increased cost of providing services, until all clients were at the maximum rate level.

There is a maximum rate for R.N. services and a maximum rate for L.P.N. services. The maximum rates are increased whenever the Colorado General Assembly authorizes and appropriates rate increases.

Reduced maximum rates are also established for one nurse providing Private Duty Nursing to more than one client at the same time in the same setting. These rates were originally based on eighty percent of the rates for one to one Private Duty Nursing, and are increased whenever the Colorado General Assembly authorizes and appropriates rate increases.

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State of Colorado

METHODS AND STANDARD FOR ESTABLISHING PAYMENT RATES- OTHER TYPES OF CARE

7. PAYMENT RATES FOR HOME HEALTH CARE SERVICES

A. Payment rates for the home health services of skilled nursing, home health aide, physical therapy, occupational therapy, and speech/language pathology services are established as follows:

1. The unit of reimbursement for home health services shall be one visit up to two and one half hours in length, except that the unit of reimbursement for home health aide services shall be changed effective March 1, 2000. For dates of service on or after March 1, 2000, home health aide services shall be billed in basic and extended units. A basic unit is the first part of a visit up to one hour. The extended units are additional increments up to one-half hour each for visits lasting more than one hour. All basic units and all extended units must be at least 15 mimutes in length to be reimbursable.

2. Payment for home health services shall be the lower of the billed charges or the maximum interim unit rate of reimbursement.

3. Maximum unit rates were established for home health services January 1, 1990 based on a single flat rate (the average weighted rate in effect 7-1-89 plus 4.5%) for each type of home health service, with the home health aide rate phased in using a step-down rate. Agencies which were projected to have a significant financial loss in the base year received the step-down rate defined as the flat rate plus .57%. The base year was the only year a step down rate was applied.

   The maximum interim unit rates for the basic and extended home health aide units, effective March 1, 2000, were calculated based on a statistically valid representative sample of visits which were reviewed to collect data on visit length. The rates were calculated to be budget neutral, and are intended to re-distribute the reimbursement proportional to actual visit length, while allowing some extra dollars for the first part of the visit to account for the fixed per-visit costs.

4. The cost of supplies used during visits by home health agency staff for the practice of universal precautions, excluding gloves used for bowel programs and catheter care, is included in the maximum per visit rate.

5. Effective February 1, 2000, interim payment rates shall be adjusted to equal no more than a department-specified percentage average increase per unduplicated client for each State Fiscal Year. The interim rates shall not be reduced, if total Medicaid home health expenditures in each State FY do not exceed appropriations. If total expenditures for the Home Health budget do exceed appropriations, the Department shall determine which Home Health Agencies received average per unduplicated client payments for State FY Home Health services which were more than the specified percentage over the previous State FY average per unduplicated client payments, and shall recoup from those agencies the amounts over the specified percentage average per unduplicated client increase. This shall be accomplished by decreasing each agency's unit rates, retro-active to the beginning of the state FY, by a percentage that will bring each agency's average payment per unduplicated client for the State FY to no more than the specified percentage increase over its previous State FY average per unduplicated client payment. Agencies that became newly certified as Medicare/Medicaid providers in each State FY and have no Medicaid Home Health payment history for the previous State FY shall be exempt for one FY.

B. Medical supplies, equipment and appliances suitable for use in the home, not including those which are the responsibility of the home health agency, as described at A.4 above, are reimbursed the lower of billed charges or the amount from the State-established fee schedule. When a maximum reimbursable cost has not been established for an item, reimbursement shall be the lower of billed charges or the provider's invoice cost plus 20% plus documented freight costs.

79-19

State of Colorado

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

8. Rural Health Clinic Services - Reimbursement shall be made according to the following:

A. For provider clinics, payment will be made on a cost per visit basis according to the principles specified in the appropriate Medicare regulations. A "provider clinic" is a clinic which is an integral part of an institution which participates in Medicare. Such a clinic must also be operated under common licensure, governance and professional supervision with other departments of the institution.

B. For any clinic that is not a "provider clinic," and does not furnish any ambulatory services other than rural health clinic services, payment will be at the reasonable cost per visit rate established for the clinic by the Medicare carrier.

C. Ambulatory services covered by the program which are not rural health services will be reimbursed according to the approved level for such services. Rural health clinic services, however, will be paid at the Medicare reimbursement rate as specified above.

D. The rural health clinic service rate per visit will be subject to reconciliation after the close of the reporting period.

E. The rural health clinic service rate per visit is also subject to HHS screening guidelines or tests of reasonableness.

TN 79-19

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RO Approved 6/10/81 Effective 10/1/79

State of Colorado

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

9. CLINIC SERVICES

Community Mental Health Center or Clinic - Reimbursement for covered services shall be made on the basis of prospective rates set for each participating community mental health center or clinic. Prospective rates shall be determined by the Colorado Department of Social Services on the basis of audited unit cost work sheets submitted by the centers to the Division of Mental Health of the Colorado Departmment of Institutions, in compliance with appropriate federal regulations.

Reimbursement for adult day health care services shall be based upon a single all inclusive payment rate per visit for each participating provider which shall be prospectively determined. The rate of payment shall be the lowest of:

a. The projected cost of such services as determined by the Division of Medical Assistance through review and audit of the proposed budget to be submitted annually by the facility. The proposed budget shall be submitted 2 months before the start of the State's new fiscal year and shall be supported by 9 months of actual costs for the current year and 3 months of projected costs for the current year. The Division shall utilize the following tests to determine the appropriateness of the proposed budget:

   (1) The previous year's audited costs adjusted forward by the annual Consumer Price Index (CPI) in effect at the beginning of the fiscal year;

   (2) Changes in the types and intensity of services to be provided; and

   (3) Costs of comparable adult day health care facilities in the State.

b. Charges by the facilities for similar services to the general public; or

c. The billed charges.

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State of Colorado

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

9. CLINIC SERVICES

Certified Health Agency - Reimbursement for covered services shall be made in accordance with the lowest of:

A. The rate determined by completing the calculation set out below using the HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS). This calculation consists of multiplying a unit value by a conversion factor.

1 Unit Values

The associated unit values shall be determined using, when available, information from three data sources:

a. Input from a consultant who reviewed such specialty area;
b. 90th percentile of charge data from basic Blue Shield;
c. The current unit value for each code (1971 RVS).

When these data are obtained, the unit value is determined as follows:

a. When information from all three of the sources listed above is available, the middle unit value is used.
b. When information from only two sources is available, the average unit value is used.
c. When only one source of information is available, the unit value indicated by this information is used.

Once the unit value is determined, it is multiplied by a conversion factor.

2. Conversion Factors

The conversion factor represents an appropriate numerical value as selected for each type of service (i.e. medicine, surgery, anesthesia, pathology, and radiology) which will, when multiplied by the appropriate unit value assigned to each procedure, determine a unique dollar value for each procedure. Details about conversion factors historically applied on specific dates are available at the Medical Assistance Program office.

B. Provider's Actual Charge.

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State of Colorado

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

9. CLINIC SERVICES

Ambulatory Surgical Center - Reimbursement for approved surgical procedures shall not exceed for each of the surgical groupings the lowest of:

1. Submitted charges.
2. 80% of Medicare rate.
3. Average Medicaid payment for the cost of one day of inpatient care.

Items and services included in the facility fee or charge shall be as a minimum:

1. Nursing services, technical personnel services
2. The patient's use of the ACS' facilities
3. Drugs, biologicals, surgical dressings, supplies, etc.
4. Diagnostic or therapeutic items and services
5. Administrative, record keeping and housekeeping items and services
6. All blood products such as whole, blood plasma, platelets, etc.
7. Materials for anesthesia

Items not included are:

1. Physician services including surgeon, assistant surgeon, and anesthesiologist
2. Sale, lease, or rental of durable medical equipment
3. Surgically implanted prosthetics
4. Ambulance services
5. Services furnished by an independent laboratory

Drug and Alcohol Treatment for Substance Abusing Pregnant Women - Reimbursement for covered services shall be the lower of either submitted charges or a fee schedule as determined by the Colorado Department of Social Services in conjunction with the Alcohol and Drug Abuse Division, Colorado Department of Health. Allowable services under the clinic option are limited to: risk assessment, case management, drug/alcohol individual and group therapy, and health maintenance group.